DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DEC 3 0 2008

Toby Douglas
Chief Deputy Director of Policy and Programs
California Department of Health Care Services
Medical Care Services
P.O. Box 997413, MS 4000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is our final report on California's Early and Periodic Screening, Diagnostic, and Treatment dental benefit. The purpose of this review was to determine what efforts California has made to address the rate of children's dental utilization in the State, and to make recommendations on additional actions Nevada can take to increase these utilization rates. CMS interviewed State and County staff, providers, and conducted extensive document review in the areas of informing, periodicity, access, diagnosis and treatment services, support services, and coordination of care. The report was previously sent to you in draft, and the final version incorporates the State's comments. This report is now subject to disclosure under the Freedom of Information Act (5 USC 552).

In addition to the review team's findings, the report offers recommendations that we believe may enhance California's dental program for children and incorporates the State's comments on the draft report. Please relay our gratitude to your staff for the assistance and cooperation they provided during our review.

We will continue to monitor children's dental utilization rates. We will follow up on the status of recommendations made in this report in June, 2009. Should you have any questions, please call Susan Ruiz of my staff at (415) 744-3567.

Sincerely,

for

Gloria Nagle
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
Region IX

California EPSDT Review Report
Dental Services
February 13-15, 2008 Site Visit

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Executive Summary

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children enrolled in Medicaid is intended to assure the availability and accessibility of required health care resources and to help children to effectively use them. With a focus on dental services, representatives from Regions IX and X, as well as the Central Office of the Centers for Medicare & Medicaid Services (CMS), conducted an on-site review of California's EPSDT program in February 2008. The purpose of the review was to determine what efforts California has made to address the rate of children's dental utilization in the State, and to make recommendations on additional actions California can take to increase these utilization rates. Specifically, we interviewed State and County staff, as well as four providers at their offices, and conducted extensive document review in the areas of informing, periodicity, access, diagnosis and treatment services, support services, and coordination of care. Subsequent to the on-site review, we conducted telephone interviews with 19 additional dental providers.

As reported to CMS on the 416 report, there were over 4.5 million children under the age of 21 eligible for Medicaid in California during 2006. All of these children were eligible to receive dental benefits. Approximately 28 percent of total Medicaid-eligible children received a dental service in 2006, as reported to CMS by the State.

The CMS review team has identified two findings and has nine recommendations for the State.

Regulatory Finding

- **Finding:** The State is not in compliance with regulatory requirements of 42 CFR 438.10(e) (2)(ii)(E) regarding managed care informing requirements.
- **Recommendation:** The State must provide, or require its contractor or health plans to provide, information to all enrollees about how and where to access Medicaid benefits that are not covered under the managed care contract, including dental benefits.
- **Finding:** The State is not in compliance with statutory requirements found at §1905(r)(5) regarding services for children.
- **Recommendation**: The State must ensure that Treatment Authorization Requests (TARS) for children under age 21 are adjudicated accurately, using EPSDT medical necessity criteria, regardless of whether the provider is familiar with or requests "EPSDT Supplemental Services."

Additional Recommendations

- The State should provide families with a single, clear document that explains Medicaid dental benefits for children, including information on the importance of preventive and routine dental care and how they can get assistance finding a dental provider.

- The State should conduct an assessment of each County's Medicaid EPSDT informing procedures, provide feedback, and share best practices.

- The State should ensure that contractor oversight includes verification of the accuracy of the referral lists it compiles.

- The State should monitor the number of dentists accepting new patients by geographic area and recruit new providers as necessary in order to ensure that dental benefits are provided to eligible EPSDT beneficiaries who request them.

- The State should review its transportation policies to assure that the mandatory assurance of transportation exists for Medi-Cal beneficiaries. The State should consider providing, or reimbursing for the provision of, transportation for EPSDT beneficiaries who need it to access medically necessary services, including dental services.

- The State should take a more active role in coordinating dental "programs" for children in order to reduce duplications of effort.

- The State should monitor the impact that the reduction in dental payment rates has on access to dental services.

General Recommendation

- The State should ensure that beneficiaries receive reminders regarding the need for periodic dental services either from the State Medicaid Agency as part of the annual EPSDT informing requirement or directly from dental service providers.

I. Background

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for children enrolled in Medicaid is intended to assure the availability and accessibility of required health care resources and to help children to effectively use them. Dental services are included in the EPSDT program coverage and there is a great deal of national interest in the provision of dental services to children covered by Medicaid.

CMS has conducted on-site reviews of children's dental services in 16 states. The States reviewed were selected based on the dental utilization rates reported by States to CMS on the CMS-416 annual report, which is used to report EPSDT program information. Primarily, the States reviewed had less than a 30 percent dental utilization rate for children. These reviews were performed to determine what efforts States have made to address the rate of children's dental utilization in their State, and to make recommendations on additional actions States can take to increase these utilization rates and ensure compliance with Federal Medicaid regulations.

In addition, Congress has requested that CMS collect information regarding dental service utilization and delivery systems from all states. While CMS has conducted a number of onsite dental reviews in some states, we collected more limited dental information by telephone from all states.

II. Scope of Review

The EPSDT program consists of two mutually supportive operational components:

- Assuring the availability and accessibility of required health care resources, and;
- Helping Medicaid beneficiaries and their parents or guardians effectively use them.

The purpose of the review was to examine what efforts California has taken to address the utilization rate of children's dental services and to make recommendations on additional actions that California can take to ensure compliance with the regulations and increase their rate of children's dental utilization.

California's review was performed by CMS representatives from Region IX and X, as well as the national EPSDT Coordinator from Central Office, on February 13-15, 2008. The California Department of Health Care Services (DHCS) is the single state agency that administers the Medicaid program in California (called "Medi-Cal"). During this on-site review CMS representatives met with the appropriate State staff from the DHCS dental program, and staff from the DHCS Children's Medical Services Branch, to gain a better understanding of how State staff ensured children receive the dental benefits to which they are entitled.

County staff at local Children's Health and Disability Prevention (CHDP) Programs were interviewed to determine how State policies are implemented at a local level. Additionally, we interviewed four dental providers on-site and performed additional telephone interviews of 19

dental providers, to gain insight about how dental practitioners view the Medicaid dental system in California. Providers interviewed saw between 5 percent and 85 percent Medicaid recipients as part of their practice. As part of this review we also reviewed data provided by the State, reviewed the dental provider manual, managed care handbooks, and dental informing materials. Dental managed care administration was outside of the scope of this review, since the overwhelming majority of children receive dental benefits in a fee-for-service environment.

III. Introduction to California Dental Services for Children

The California Department of Health Care Services (DHCS) is the single State Agency that administers the Medicaid program in California (called "Medi-Cal"). The Medicaid dental program is commonly known as "Denti-Cal." Eligibility for Medicaid is determined at local County offices. Eligibility workers determine Medi-Cal eligibility and inform Medicaid applicants and recipients about EPSDT benefits. Local workers who inform families of EPSDT benefits are trained about these benefits by local Children's Health and Disability Prevention Program (CHDP) staff. CHDP is a State program under DHCS and has a local presence in all 58 counties in California. CHDP began as a way to implement Early and Periodic Screening mandates but has expanded to assure that all low-income children and youth in California have access to preventive health care services. The program offers physicals, immunizations, vision, hearing, and dental screenings. When necessary, County CHDP staff assists the family with scheduling and transportation assistance, and in obtaining follow up services. Depending on the county, local CHDP staff may also administer Title V Maternal and Child Health programs and other children's public health projects.

As reported to CMS on the 416 report, there were over 4.5 million children under the age of 21 eligible for Medicaid in California during 2006. All of these children were eligible to receive dental benefits. Approximately 28 percent of total Medicaid-eligible children received a dental service in 2006, as reported to CMS by the State. Approximately 95 percent receive services through the State's fee-for-service program, while the other five percent receive dental care through a managed care organization. California has more than 7,000 enrolled dental providers that are actively billing. Some of these providers are large practices employing additional providers. However, almost 1,600 providers billed less than $1,000 in 2006.

DHCS employs a contractor to administer the dental fee-for-service program and act as the State's fiscal agent. The contractor pays claims at rates set by the State agency, adjudicates prior authorization requests, enrolls qualified providers at the provider's request, performs outreach activities, and provides a toll-free number for referrals to participating dentists. For performing these activities, the contractor receives a flat monthly rate per beneficiary.

Review Descriptions, Findings, and Recommendations

Key Area I- Informing Families on EPSDT Services

Section 5121 of the State Medicaid Manual provides the requirements for informing Medicaid beneficiaries of the EPSDT program, including dental services, in a timely manner. Based on section 1902(a)(43) of the Act, States are to assure there are effective methods to ensure that all eligible individuals and their families know what services are available under the EPSDT program; the benefits of preventive health care, where services are available, how to obtain them, and that necessary transportation and scheduling assistance is available. Regulations at 42 CFR 438.10 require the State, its contractor, or health plans to provide information to all enrollees about how and where to access Medicaid benefits that are not covered under the managed care contract. No methodology is mandated to states to determine the "effectiveness" of their methods, nor are States required to measure "effectiveness" of their informing strategies. Informing is particularly important with respect to dental services since many families do not see dental services as a priority and may need additional information on these important services.

In California, County CHDP staff train county eligibility workers about what CHDP is and what benefits are provided. When a family is interviewed for Medicaid eligibility, the eligibility worker explains the benefits the Child Health and Disability Prevention program provides and asks if they would like more information about CHDP. There is also a box to check on the Medicaid application if families want more information. Eligibility workers generate a referral for families who indicate verbally or in writing that they want more information, and CHDP staff contact the family directly. CHDP has a brochure about the importance of health screenings, including dental screenings and treatment, and the local number to contact for assistance.

Additionally, Medicaid beneficiaries receive a booklet entitled "Medi-Cal: What it Means to You." It explains generally who is eligible for Medicaid, what documents may be required, Medicaid managed care, how to use a Medicaid card, and how the Medically Needy share of cost program operates. This booklet gives a toll-free number to call for dental referrals. It also mentions that some dental benefits require prior approval. This booklet explains that EPSDT services correct or improve medical, dental, or mental health problems.

Depending on the county in which they live, new enrollees also receive information about selecting a managed care plan, primary care physician, and how managed care works. Dental benefits are carved out of the physical health plans and provided fee-for-service or through dental managed care plans. While dental managed care was not within the scope of this review, the review team looked at member handbooks for all physical health plans enrolling children to ensure that information was provided describing how to access dental services. The review team found wide variation. While most plan handbooks provide the toll-free number for assistance locating a participating dentist, a few do not mention dental benefits at all.

- ***Finding #1***: The State is not in compliance with regulatory requirements of 42 CFR 438.10(e) (2)(ii)(E) regarding managed care informing requirements.

- ***Recommendation* #1:** The State must provide, or require its contractor or health plans to provide, information to all enrollees about how and where to access Medicaid benefits that are not covered under the managed care contract, including dental benefits.

- ***State's response:*** The Department of Health Care Services (DHCS or Department) is in compliance with this requirement, as DHCS contracted health plans are required to provide the mandated information. Medi-Cal Managed Care Division's (MMCD) contracts currently require health plans to develop and provide each member or family unit a Member Services Guide that meets the requirements of Evidence of Coverage and Disclosure Form (EOC/DF) as provided in Title 28 California Code of Regulations (CCR) Section 1300.51(d) and its Exhibit T (EOC) or U (Combined EOC/DF), if applicable. The contract specifies what must be contained in the Member Services Guide. Guides are required to include a description of the carved-out services, an explanation on how to use the Fee-For-Service system when Medi-Cal covered services are excluded or limited under the contract, and how to obtain additional information.

  Managed care contracts also require plans to submit the Member Services Guide to DHCS for review prior to distribution to members and to comply with the annual informing requirements contained in Title 22 CCR Section 53895 which may be met through issuance of the Member Services Guide.

  MMCD understands that a few plans' Member Services Guide did not contain information on how to access dental benefits. To address this, MMCD will issue an All Plan letter by December 2008, reminding the plans that this information must be included in the Member Services Guide. MMCD will coordinate with DHCS' Medi-Cal Dental Services Branch (MDSB) with regard to the language that should be included. MMCD will also revise the tool used to assist staff in reviewing the Member Services Guide and have staff more closely review the guides to ensure they contain information on accessing dental benefits.

  CMS response – The State has discretion on how to meet the requirements outlined in 42 CFR 438.10. If the State elects to include this informing in the contract with health plans, it is CMS' expectation that the State enforce the terms of the contract. Instead of a letter to all plans, we would like MMCD to identify and notify the specific plans that do not currently include information regarding how to access dental benefits in the Member Services Guide. Please provide us with copies of these letters when they are sent.

- ***Recommendation #2*** – The State should provide families with a single, clear document that explains Medicaid dental benefits for children, including information on the importance of preventive and routine dental care and how they can get assistance finding a dental provider.

  State's response: The State does have materials that inform families about the availability of dental benefits for children, including the Medi-Cal brochure provided to all enrollees and the CHDP brochure.

Additionally, in response to requests from beneficiary advocates, MDSB has started developing an informative brochure for dental services that is envisioned being distributed at the county level where eligibility is determined. DHCS will ensure this brochure clearly explains Medicaid dental benefits for children, including information on the importance of routine dental care, and how they can get assistance finding a dental provider. This will be done in cooperation with beneficiary advocates to ensure the information is clear, appropriate, and useful to the Medi-Cal population. This information will also be available on the Medi-Cal website.

CMS response – CMS acknowledges that many documents explaining benefits exist. We are pleased that the State has already begun developing a single clear document explaining dental benefits. Please provide CMS with a copy of the dental informing brochure when it is complete.

- ***Recommendation #3*** – The State should conduct an assessment of each County's Medicaid EPSDT informing procedures, provide feedback, and share best practices.

State's response: In administering this program, DHCS routinely provides information, guidance, and feedback on counties regarding EPSDT. Best practices are shared when applicable. These activities are carried out on a continual basis. While the Department endorses the recommendation of a comprehensive assessment of each county's informing procedures, the current State budget situation does not allow for additional resources to conduct such an assessment at this time.

CMS response – Section 1902(a)(43) of the Social Security Act requires states to ensure effective informing methods. We are pleased the State agrees in principle to the concept of comprehensive reviews of informing effectiveness. Please provide CMS with a list by each county of how many children were referred to CHDP in 2007 within 90 days of receipt of this report.

Key Area II- Periodicity Schedule and Interperiodic Services

Section 5140 of the State Medicaid Manual provides the requirements for periodic dental services and indicates that distinct periodicity schedules must be established for each of these services. Sections 1905(a)(4)(B) and 1905(r) of the Act require that these periodicity schedules assure that at least a minimum number of examinations occur at critical points in a child's life.

The State's dental periodicity schedule requires an annual visit to a dental provider beginning at age three. In June 2004, CHDP sent a notice informing providers, in accordance with the recommendation of the American Academy of Pediatrics (AAP), that a direct referral to a dentist is recommended beginning at age one and annually thereafter, and that the State will pay for cleanings twice a year without prior authorization.

There are no recommendations in this area.

Key Area III- Access to Dental Services

The State must provide, in accordance with reasonable standards of dental practice, dental services to eligible EPSDT beneficiaries who request them. The services are to be made available under a variety of arrangements, in either the private or public sector. States are to assure maximum utilization of available resources to optimize access to EPSDT dental services, with the greatest possible range and freedom of choice for the beneficiaries and encouraging families to develop permanent provider relationships. When dental services are provided through a managed care arrangement, regulations require states to include contract language with plans to monitor over- and under-utilization, and to maintain and monitor a network of providers sufficient to provide adequate access. For all States, section 42 CFR 440.100 specifies that dental services are to be provided by, or under the supervision of, a dentist qualified under State law to furnish dental services. States may also utilize other oral health resources coverable under the Medicaid program.

California has more than 7,000 enrolled dental providers that are actively billing. Some of these providers are large practices employing additional providers that bill using the same provider number. Additionally, there are 299 Federally Qualified Health Centers that provide dental services. Including all providers that render services, California has over 12,000 dental providers. If a provider does not bill Medicaid for one year, their provider number is automatically "inactivated" and is not included in the count of providers mentioned above.

The State oversees the Medicaid dental program as a traditional fee-for-service Medicaid program. Providers are enrolled upon request, but neither the State nor its contractor take an active role in assuring adequate provider networks. The contractor offers assistance to enrolled providers and attends health fairs and other functions. Neither the State nor its contractor have a process in place to ensure beneficiaries have a dental home, nor do either perform beneficiary-specific outreach.

The State has considered approaches to increase provider participation and beneficiary utilization. Most recently at the end of 2007, in conjunction with the California Dental Association, providers were sent a survey asking about the Medicaid dental program. Provider feedback included suggestions to increase provider reimbursement rates, complaints about patients with poor oral health, and complaints about the greater documentation requirements when submitting a claim to Medicaid than to other insurers. These are largely the same concerns cited in the State's 2001 Dental Action Plan provided to CMS, and are the same issues the review team heard on site from the providers visited and interviewed by phone. State staff noted to the review team that some of the documentation requirements are in place due to State laws and anti-fraud measures. While the State acknowledges their low utilization rates for children, we also heard that State budget constraints prevent the State from implementing changes at this time. Governor Schwarzenegger proposed eliminating $1 billion from the Medicaid program by cutting Medicaid reimbursement rates by 10 percent to providers, including dental providers that treat beneficiaries. The State was due to implement this change on July 1, 2008. However, this has been a controversial proposal and its status is unclear.

The State's dental contractor maintains a toll-free number for beneficiaries to call to find a participating Medicaid dentist. The contractor compiles a list of dental providers who want to be on the referral list and who are accepting new patients. Providers are tracked according to geographic area as well as by age of children seen. When a beneficiary calls the toll-free line, they are given the contact information for several dentists in their area. However, the two local CHDP offices we visited found the list to be inaccurate often enough that they compile their own, including providers in neighboring counties that may see children. Two dentists we interviewed, one on-site and one by phone, told us they had stopped accepting new Denti-Cal patients, but had been unable to remove their names from the referral list provided by the contractor.

Although there are a number of activities taking place in California that may impact dental care for children in Medicaid, there is no apparent coordination of effort at a statewide level. Clearly, many organizations in California are working to improve children's oral health, and serve more than Medicaid children. Medicaid's role in these programs is more as a payer than as coordinator, which could lead to duplications of effort. An example of these programs includes First Smiles, a project funded by the California Children and Families Commission, which trains general dentists to see children. They have trained thousands of dentists, and the State believes this will have a positive impact on access for children. As another example, CHDP has put together an Oral Health Handbook for its medical providers. This handbook provides information to medical providers about dental disease and oral health and includes parent education materials. In addition, there are Maternal and Child Health initiatives that focus on oral health, and the Department of Public Health funds a Childhood Dental Disease Prevention Program.

- ***Recommendation #4*** – The State should ensure that contractor oversight includes verification of the accuracy of the referral lists it compiles.

- ***State's response*** – The State does oversee the Dental FI to assure accuracy of the referral list to the best extent possible. The referral list and Denti-Cal website are updated regularly for changes in status as provided by participating dentists. In addition, all providers on the referral list are asked to validate their information annually, including that they are accepting referrals. However, the fact that a provider is on the list does not ensure that the provider is able to accommodate referrals at any specific point in time. For example, if a beneficiary calls a referred provider seeking an appointment on a particular date or week, if the provider has no available appointments during those times it may be perceived that the referral was inaccurate. These circumstances are not unusual. Therefore, the list may appear to be inaccurate when in fact it is not; instead, it is a matter of that provider not being available at the time of the particular referral.

  Denti-Cal makes over 122,000 referrals a year, all of which are confirmed in writing to the beneficiaries. When the beneficiary notifies Denti-Cal that the referrals did not work out, efforts are made on their behalf to locate a provider who is available.

  CMS response – It is possible that what we heard about the accuracy of the provider lists may have been due, in part, to a patient being unable to obtain an appointment at the time

and date of their choice. It is unclear from the State's response how accurate DHCS believes the list of providers accepting new patients to be. If DHCS believes it to be accurate, DHCS should work with CHDP to eliminate or reduce their need to compile duplicate resources. If DHCS believes the list is inaccurate, DHCS should work with the contractor to improve it.

- ***Recommendation #5*** – The State should monitor the number of dentists accepting new patients by geographic area and recruit new providers as necessary in order to ensure that dental benefits are provided to all eligible EPSDT beneficiaries.

- ***State's response*** – This is a contractual obligation of Delta's Denti-Cal Outreach Unit. Much of the outreach activity is focused on Federally Qualified Health Centers (FQHC) and Indian Health Centers, as they are often the primary providers in underserved areas. Although they do not bill Denti-Cal, these centers must follow Denti-Cal program criteria. Working with these clinics increases utilization of dental services by Medi-Cal beneficiaries, although not specifically in Denti-Cal. MDSB will continue to monitor this activity, and ensure that outreach efforts are focused on recruitment and retention of providers for EPSDT beneficiaries.

  CMS response – We applaud the State for their contractor's outreach efforts with FQHCs and Indian Health Centers. Our recommendation is to see these outreach and recruitment efforts expanded to other dental providers as well.

- ***Recommendation #6*** – The State should take a more active role in coordinating dental "programs" for children in order to reduce duplications of effort.

- ***State's response*** – The State does take a very active role in coordinating dental "programs" for children. There are several mechanisms for coordination of dental programs that are currently in place. One is the State Action Plan Team which meets approximately once per month and includes staff from CMS (which includes CHDP and CCS) Children's Dental Disease Prevention Program (CDDPP), Maternal, Child, and Adolescent Health (MCAH), Medi-Cal Managed Care, California Dental Association (CDA), First 5, Alameda County Public Health Department, University of California Office of the President and American Academy of Pediatrics. Another is a DHCS/California Department of Public Health (CDPH) workgroup that meets quarterly and includes staff from CMS, CDDPP, MCAH, University of California San Francisco (UCSF), Dental Health Foundation and CDA. In addition, there is a State CHDP Dental Subcommittee that meets quarterly and a Bay Area CHDP Dental Subcommittee that meets monthly. These forums include staff from all the programs cited in the federal CMS report and MDSB dental staff participates in all of them.

- ***CMS response*** –While we are pleased to hear about State representation on dental workgroups, we believe stronger State leadership in coordinating the many different dental "programs" in place for low-income children will serve to increase children's dental utilization. Because many of the groups listed above receive some Medicaid funding, we are concerned that in the absence of strong leadership and coordination

across the groups, there may be duplicate payments for these activities. Beyond sending appropriate representatives to meetings, the State should ensure that representatives at these meetings have the authority necessary to take action to eliminate barriers to care as identified by these groups.

- ***Recommendation #7*** – The State should monitor the impact that the reduction in dental payment rates has on access to dental services.

  State's response – The Department routinely monitors access to and utilization of dental services through a variety of monthly, quarterly, and annual utilization reports. In addition, programming changes are currently being made that will make the information collected for use in the CMS-416 report available interactively by county, by any individual age or age group, by sex, by type of plan (fee-for-service or managed care) by any category of eligibility and for any period of time. These changes will greatly aid our ability to more closely monitor the impact of any program changes and where to target any necessary intervention.

  CMS response – We are pleased the Department is taking steps to enhance the monitoring process and look forward to the new CMS-416 report.

Key Area IV- Diagnosis and Treatment Services

Children under the age of 21 may receive additional benefits under EPSDT when determined to be medically necessary by the State. EPSDT requires that services for children under age 21 not be limited to services included in the State's Medicaid Plan, but only by what is coverable under section 1905(a) of the Act. Diagnostic services must fully evaluate any dental condition identified, while treatment services must ensure that health care is provided to treat or ameliorate the dental condition. Section 1902(a)(10) of the Social Security Act and regulations found at 42 CFR 440.240 require that services provided be comparable in amount, duration, and scope for all recipients within an eligibility group. Dental benefits are an optional service that states are not required to cover for adults.

The State's provider manual and a Denti-Cal bulletin from December 2006 both accurately describe EPSDT services. Both describe "EPSDT Supplemental Services" as services available to children even though not generally within the scope of benefits of California's Medicaid program. It also outlines that a service may be requested for a child even if the child does not meet the usual criteria for the service. State dentists, not the State's contractor, adjudicate "EPSDT Supplemental Services" requests. In 2007, there were only 193 requests in the State.

Certain dental benefits, such as laboratory-processed crowns, root canals, and dental implants, require a Treatment Authorization Request (TAR). The State's Denti-Cal manual gives instructions for completing a TAR. A provider must indicate "EPSDT Supplemental Services Request" on the form if they want it adjudicated using the EPSDT criteria. In addition to documentation that would normally be provided to support a TAR, the provider must also include a "clinical rationale for why a covered benefit or lower-cost service will not suffice (you

are encouraged to include copies of published clinical studies or articles from peer-reviewed, professional dental journals to support your rationale)." The contractor provides the State with a monthly report of prior authorization processing times, claims processing times, claims processing accuracy, payment accuracy, etc., but the program does not have performance goals to increase utilization.

After a provider submits a TAR, the contractor must approve, deny, or ask for further information within 15 calendar days. The provider may not initiate treatment while the TAR is being processed. The contractor provides the State with a monthly report of the timeliness of these adjudications. Three of the four dental providers and both CHDP offices told us that certain services were not covered under the Medicaid dental benefit. This was also noted in several of the additional provider interviews done by telephone. Anecdotally, providers report the following denied services for children:

- Quarterly cleanings for a disabled child unable to brush her teeth
- Sedation
- Treatment at a pediatric dentist, after an exam at a general dentist
- Laboratory processed crowns, even when more appropriate than a filling.

It is unclear whether anecdotal reports of TARs denied inappropriately reflects a professional difference of opinion, a provider education issue, or a compliance issue. The additional provider interviews by phone resulted in information consistent with the onsite interviews. Additionally, the State performed an analysis of the medical accuracy of the contractor's TAR adjudications in 2007. They examined a sample of TARs for laboratory processed crowns and a second sample for amalgams, composite, and stainless steel crowns. The State found the contractor's error rate to be 26 percent and 20 percent, respectively. Errors fell into four categories:

- Services that should have been authorized,
- Services that should not have been authorized,
- Improper use of adjudication codes, and
- Inconsistent adjudication.

The State also found the contractor to be inappropriately denying laboratory-processed crowns for teenagers. This was the only documentation of monitoring of clinical appropriateness of TAR adjudications by the State provided to the review team.

- ***Finding #2:*** The State is not incompliance with statutory requirements at section 1905(r)(5) regarding the provision of all medically necessary services to EPSDT eligibles.

- ***Recommendation #8***: The State must ensure that Treatment Authorization Requests (TARS) for children under age 21 are adjudicated accurately, using EPSDT medical necessity criteria, regardless of whether the provider is familiar with or requests "EPSDT Supplemental Services."

State's response – The State does comply with this provision. The Denti-Cal Fiscal Intermediary (FI), Delta Dental, is contractually responsible for ensuring the quality/accuracy of adjudications of TARs. In turn, MDSB monitors this activity to ensure the contractual obligations for accuracy are met. MDSB also conducts ad hoc reviews of TAR adjudication. And, MDSB resolves provider and beneficiary issues and complaints that it receives, which provides further opportunity to review and assess the accuracy of adjudication.

With regard to EPSDT Supplemental Services (SS), children's dental care differs from medical care in that the clinical determination of medical necessity can be determined directly from the submitted oral radiographs. We estimate that in 98 percent of children's treatment claims and TARs, the medical necessity for treatment can be established by radiograph alone, with occasional supplementation by intraoral photographs. California's EPSDT-SS regulations were intended primarily for orthodontic cases that failed to score the necessary 26 points (or failed to possess one of five automatic qualifying conditions) to receive case-by-case consideration. At the bottom of every Handicapping Labial-Lingual Deviation (HLD) Index Score sheet provided to enrolled orthodontists is a detailed explanation of the EPSDT-SS process. The EPSDT-SS process is also available to dentists for the consideration of any professionally recognized and accepted procedure or technique that is not experimental, investigational, or for cosmetic reasons only. MDSB believes that the submission of only 173 EPSDT-SS TARs in 2007 demonstrates that the current process for the determination of medical necessity is sufficient for our EPSDT beneficiaries and their providers.

To further ensure the accuracy of TAR adjudication, MDSB is developing and implementing a structured review process whereby MDSB dentists will routinely review a sample of TARs for accuracy in the application of clinical criteria and the determination of medical necessity for EPSDT. MDSB dentists will meet with Delta's professional review staff on a regular basis to discuss their findings and formulate corrective action plans.

CMS response – The State is responsible for ensuring the provision of medically necessary services to EPSDT eligibles. A 20% error rate does not meet requirements of §1905(r). However, we are pleased to hear about the implementation of the structured review process described. Please provide us with specific details of this process, including the frequency of these reviews, implementation date, sample size, percentage of children's services, and findings.

Key Area V- Support Services

Section 5150 of the State Medicaid Manual indicates that the State is required to ensure that beneficiaries have adequate assistance in obtaining needed Medicaid services by offering and providing, if requested and necessary, assistance with scheduling appointments and non-emergency transportation. This includes the regulatory requirement of 42 CFR 431.53 mandating an assurance of transportation.

The review team was told by the State that support services would vary by county, since these services are provided through local CHDP offices. In both counties visited, CHDP staff has developed their own network of dental providers in their local community. CHDP staff will assist a family to find a provider and make an appointment. If a family has no transportation of their own, they assist in navigating a public transit route to get to a provider. In some cases, the provider may be several Counties away. CHDP staff try to make sure the family keeps the appointment, and will call and remind parents of the appointment. Counties may provide some transportation to Medicaid services and receive Federal matching funds, but this is not required by the State and varies by County.

States are not required to provide transportation, but are obligated to ensure that necessary transportation is available to and from providers. California provides transportation only when a specialized vehicle is required. When a specialized vehicle is not required, the State Plan provides an assurance of transportation by referring to the other many programs within California that may offer transportation assistance, including CHDP. CHDP staff indicated that efforts to arrange for necessary transportation have not consistently succeeded because of the absence of funding to pay for transportation. None of the providers interviewed were aware of any transportation assistance available to beneficiaries. The scope of this review did not include gathering comprehensive information to determine if the State's assurance of transportation is effective or if the lack of readily available transportation is a barrier to improving CMS 416 screening rates, but we are concerned the State may be out of compliance with 42 CFR 431.53.

- ***Recommendation #9*** - The State should review its transportation policies to assure that the mandatory assurance of transportation is meeting its purpose and that recipients are not forgoing dental care.

  State's response – The State does provide for transportation to access medically necessary services available under the EPSDT benefit for children. Over the years the California Children's Services (CCS) program has fulfilled this requirement through provision of instructions to county CCS programs on authorizing reimbursement for transportation to enable Medi-Cal beneficiaries with a CCS eligible medical condition to access services authorized by the CCS program. The CCS program has been able to draw down Medi-Cal administrative funding for reimbursements made to families for the transportation of CCS children who are Medi-Cal beneficiaries.

  In addition, local Children's Health and Disability Prevention (CHDP) programs assist families in making arrangements to get children eligible for fee-for-service Medi-Cal to medical and dental appointments. This ad hoc assistance varies by local program.

  CMS response – California Children's Services covers a vulnerable population of seriously ill children. We are pleased that CCS provides transportation and transportation reimbursement for this very small subset of the Medi-Cal population. However, we are concerned about the State's description of assistance for non-CCS children being "ad hoc." If the assurance of transportation does not exist statewide, the State is not in compliance with 42 CFR 431.53. We encourage the State to allow CHDP to participate

in the same, or similar, mechanism used by CCS to ensure transportation to medically necessary services. As part of CMS' follow up to this report, we plan to investigate this matter further.

Key Area VI- Coordination of Care

Regulations found at 42 CFR 438.208 require the coordination of health care services for all managed care enrollees. Section 5240 of the State Medicaid Manual describes the use of continuing care providers which encourages coordination of care.

Coordination between a primary provider and a dental provider does not generally occur, however, coordination may be particularly important for special needs children who may be receiving medications and treatments that may affect their oral health. According to the State, children with special health care needs receive care coordination for medical services, including dental care.

There are no recommendations for coordination of care.

Key Area VII - Data collection, analysis, and reporting

Section 2700 of the State Medicaid Manual delineates EPSDT reporting requirements, consisting of the annual CMS-416 report. This report requires States to report by age groupings the number of children receiving medical and dental services. The CMS 416 includes three separate lines of dental data as defined by CDT codes: the number of children receiving any dental service, the number of children receiving a preventive dental service, and the number of children receiving a dental treatment services. The CMS-416 report is to be submitted no later than April 1 after the end of the federal fiscal year. The Centers for Medicare and Medicaid Services uses this report to monitor children's utilization of medical and dental services on a state by state basis.

The State has submitted its CMS-416 for 2007. Twenty-eight percent of children were reported to have received a dental service, the same as in 2006.

There are no recommendations for data collection, analysis, and reporting.

IV. Conclusion

CMS looks forward to working in partnership with the State to enhance and improve EPSDT dental services to children. The CMS review team made recommendations in the areas of informing and monitoring, access to dental services, diagnosis and treatment, and support services as to specific actions the State of California should take to increase the utilization of dental services by children. While increases in dental utilization have occurred, they are insufficient if less than 30 percent of children are accessing dental services as indicated on the CMS-416 form. We expect the State to take actions to address the recommendations detailed in

this report in an effort enhance utilization rates for children's dental services. We expect the State to submit a plan of action addressing compliance with managed care informing pursuant to 42 CFR 438.10(e) (2)(ii)(E), and for providing medically necessary services for children as required by §1905(r)(5) of the Social Security Act.